THE INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE

Witness Statement of Lesley Hagger

I, Lesley Hagger, will say the following:-

1. The documents attached contain all the information held by Northamptonshire County Council in relation to the matters detailed in your letter of 7th February 2018. They are named LH1- LH15
2. I would like to take this opportunity to apologise for the delay in provision of these details; this occurred because the letter requests sent to me were delayed in reaching me and, as such, this information was not provided sooner.
3. In respect of details referred to in your letter as occurring on 23.02.14.
    a. I am submitting all documents held by Northamptonshire County Council in relation to this matter.
    b. The incident occurred on 23.12.14. There was a delay in reporting the information and it was eventually reported to MASH and LADO on 08.01.15 by Rainsbrook.
    c. The discovery of the incident followed a Deputy Residential Manager becoming aware of a rumour circulating between trainees about an incident that had taken place. This led to a review of CCTV and an internal investigation which uncovered details referred to in the incident.
    d. Following this, Rainsbrook took appropriate action - in respect of commissioning an internal investigation of the staff concerned. They made a referral to MASH (Multi-Agency Safeguarding Hub) (LH 1 and LH 2) and LADO (LH 3) regarding this incident.
    e. Upon my review of the detail, the referral to MASH was not managed in an appropriate manner. Within referred information it states that the young person did not want to make a complaint and, therefore, records there is no role for children's services in relation to the young people concerned; this is not an acceptable response.
    f. There is no reference to significant harm experienced by the young person, nor the complex needs of the young people concerned. The outcome was for staff conduct to be addressed by Rainsbrook / LADO.

g. This decision appears to have been made without due consideration to s47 CA (1989) and Working Together. Through review of the information available to me, this young person had suffered significant harm and, therefore, a strategy discussion and s47 should have taken place. This would have facilitated an opportunity for him to be spoken to about the incident and appropriate action(s) taken as a result of investigation findings.

h. The concern is compounded following e-mail dated 30.01.15 (LH 5) which raises additional concerns about the unit and the treatment of this young person. In this particular instance there is no record that the LADO in post at the time raised these issues with MASH or took any additional action following receipt of the information received.

i. LADO JEM minutes (LH 4 and LH6) identify that staff members involved were dismissed or resigned and concerns regarding their conduct were 'Substantiated'.

j. As a resulted of this finding it was agreed that Rainsbrook would make a referral to the DBS.

k. It is my view that the practice in this instance falls below the standards I expect for safeguarding young people in Northamptonshire. I would want to take this opportunity to reassure you that, since this time, we have taken steps within the organisation to ensure that this would not happen again. We are currently redesigning our MASH service and are offering training and support to all staff to improve their understanding and application of threshold in relation to significant harm.

4. In relation to the second incident, for which information has been requested, this has been difficult to progress. From my review of our records and from speaking to Rainsbrook staff, we believe the incident referred to is the incident of 30/04/14 (LH 8-11).

5. The detail we hold in respect of this incident describes a physical restraint only; however, in discussion with a Rainsbrook staff member (Wendy Picken) our current Designated Officer has been informed that she remembers this incident.

6. The LADO recording in relation to this matter is very brief and of poor quality (LH10-11). There is no clear summary recording of what is alleged to have taken place and, again, this is not the standard of practice that I expect.

7. Also, in this instance, MASH has minimised the concerns raised and, despite the young person evidencing bruising, appropriate safeguarding procedures were not followed.

8. Having reviewed the records, the information held is sparse and evidences failure to ensure safeguarding procedures were followed. In relation to the Designated Officer engagement, these incidents occurred at a time of churn within the service and, whilst this cannot excuse the practice I have seen, I offer this as an explanation of how these incidences were investigated at the time.
9. NCC's current Designated Officers are now permanent staff members who have both been in the role for more than 18 months and are part of a stable management team. This allows for more robust, consistent management of safeguarding issues and scrutiny. NCC's Designated Officers use management structures and escalation policies to ensure correct actions are taken in relation to safeguarding children.
10. Further to this, in relation to MASH, this is in the process of being redesigned, supported by on-going training and development for staff. In no way am I seeking to excuse previously identified failings in practice, I would want to offer reassurance that, as a Local Authority, we are aware of these issues and are working hard to ensure improvements are sustained through service redesign and development.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: DPA

Dated: 4th April 2018